Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – DRG Methodologies and Related Issues

Table A: Comparison of Washington Medicaid and Highest Scoring States

Task	Questions	Washington	Ohio	Pennsylvania
3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	• Washington State Medicaid currently uses the AP-DRG Grouper Version 14.1. • Washington State Medicaid is considering the new AP-DRG version 21.0 for implementation in SFY 2007 or 2008.	• Ohio Medicaid uses the CMS DRG grouper Version 15.0 distributed by Health Services, Incorporated, a software package used by Medicare during Federal Fiscal Year 1998.	• Pennsylvania Medicaid uses CMS DRG Grouper version 22 as of September 2005. The Department is considered switching to the AP-DRG Grouper.
3	How are the DRG conversion factors determined (methods & variables)? Describe?	• To calculate the conversion factor for a base year, Medicaid estimates total hospital Medicaid costs by summing the Medicaid routine accommodation and ancillary costs for the operating, capital and direct medical education components for DRG-based claims. Medicaid then divides these total costs by the number of Medicaid cases during the base year to estimate average Medicaid cost per AP-DRG admission. Each hospital's Medicaid average cost is adjusted by the DRI inflation factor and the hospital-specific case-mix index. • Payments to hospitals for inpatient services are paid based on the DRG	• To calculate the conversion factor, Ohio calculates hospital-specific cost per discharge amounts using the data from the ODHS 2930 "Cost Report" (state-specific) and the Form CMS 2552 Medicare cost report. These documents reflect costs associated with the hospital's 1985 or 1986 fiscal year reporting period. • Calculated costs are further adjusted as follows: – Cost of blood replaced by patient donors is removed – PSRO/UR costs are added – Unallowable malpractice insurance costs are removed. – Direct and indirect cost of medical	• Hospital-specific conversion factors are based on the case mix adjusted hospital cost per discharge from FYE 1987, and updated annually for inflation. • Conversion factors are calculated as follows: – Base year allowable costs are determined from the hospital's base year Fiscal Year 1986-87 Cost Report. Inpatient Medicaid costs for direct medical education and depreciation and interest for buildings and fixtures are excluded. – Base year allowable costs are adjusted to account for the differences between days reported on the cost report and days calculated from the paid claims database for the base year.

Task	Questions	Washington	Ohio	Pennsylvania
		payment methodology, with the following exceptions: – The following hospitals are exempt from the DRG methodology: ▪ Rural hospitals (peer group A) ▪ Out-of-state non-border hospitals ▪ Freestanding psychiatric hospitals and distinct part units ▪ Freestanding rehabilitation hospitals and distinct part units ▪ Military hospitals ▪ CPE hospitals ▪ Critical Access Hospitals ▪ Detoxification units ▪ Fred Hutchinson Cancer Research Center ▪ LTAC hospitals – The following services provided in	education are removed – Capital-related costs are removed – The effects of wage differences for hospitals in the teaching hospital peer group are removed – For teaching and children's hospitals, an outlier set-aside (or, "outlier adjustment amount") is calculated. This amount is subtracted from the cost per discharge for each peer group. – The cost per discharge is adjusted for coding by dividing the average cost per discharge by 1.005. – The peer group average charge per discharge for the teaching hospital peer group is adjusted using a wage factor – this wage factor is based on medical education costs and the labor portion of the Medicaid inpatient cost – Costs are adjusted for inflation using an Ohio-specific inflation factor. • The conversion factor is calculated differently for different types of hospitals	– Each hospital's net cost equals Adjusted Net Medicaid Allowable Costs minus each of the following: ▪ The cost outlier portion of costs for claims that qualify as cost outliers. ▪ Day outlier portion of costs for claims that qualify as day outliers. ▪ The costs of transfer claims except for DRGs 385 and 456. ▪ The costs of the hospital's claims which are no longer paid as inpatient claims. ▪ The cost of psychiatric claims exclusive of the first 2 days of the hospital stay, for hospitals without a distinct part psychiatric unit enrolled in the MA Program. ▪ The full costs of psychiatric claims, for hospitals with a distinct part psychiatric unit enrolled in the MA Program. ▪ The costs of drug and alcohol claims exclusive of the first 2 days of the

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		DRG hospitals are also excluded from the DRG payment methodology: ▪ Neonatal services in DRG classifications other than DRG 620 and 629 ▪ AIDS-related services ▪ Bone marrow transplant services and most other transplant services ▪ Alcoholism treatment and detoxification services ▪ Pregnant women services ▪ Rehabilitation services ▪ Pain treatment services ▪ DRG low cost outliers ▪ Long term care services ▪ DRGs with unstable DRG relative weights • Most exempt hospitals and services described above are paid based on the	as follows: – Children's hospitals --- 100 percent hospital-specific – Rural referral center hospitals – peer group average – Teaching hospitals – peer group average – Non-metropolitan statistical average area hospitals with less than 100 beds – peer group average – Non-metropolitan statistical average area hospitals 100 or more beds – peer group average – Metropolitan statistical average hospitals – peer group average – these hospitals are peer grouped on the basis of wage index categories – Out-of-state hospitals – Average cost per discharge that varies based on hospital type (teaching hospital, children's hospitals and all other).	hospital stay, for hospitals that are not approved for drug and alcohol detoxification services. ▪ The full costs of drug and alcohol claims, for hospitals with a distinct part drug and alcohol unit enrolled in the MA Program. – The hospital's net cost is reduced by an over-reporting factor of 1.77% to account for the effects of audit adjustments that have not yet been made. – The hospital's net cost is divided by the adjusted number of Medicaid cases for that year to calculate the hospital's average cost per case. – The hospital's average cost per case by the hospital-specific is divided by the case mix index to calculate the Base Year Case Mix Adjusted Cost per Case. .

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		RCC methodology. • Washington State Medicaid multiplies aggregate costs by an inflation factor determined by the rebasing staff for the period January 1 of the year after the base year through October 31 of the rebase year. Medicaid subtracts any outlier set-aside percentage from inflation adjusted aggregate costs to estimate a hospital specific adjusted Cost-Based Conversion Factor (CBCF). • In urban hospital peer groups (peer groups B and C), the Medicaid average cost per case is capped at the 70th percentile of the peer group average.		
3	Is there a geographic component to the conversion factor setting methodology? Describe?	• Other than distinguishing between urban and rural in its peer groups, Medicaid does not include a geographic component into the conversion factor setting methodology.	• The conversion factors are determined by peer groups, and these peer groups are, in part, based on geographic area – specifically: – Rural referral center hospitals – peer group average – Non-metropolitan statistical average area hospitals with less than 100 beds –	• No. Rates are based on facility-specific costs.

Task	Questions	Washington	Ohio	Pennsylvania
			peer group average – Non-metropolitan statistical average area hospitals 100 or more beds – peer group average – Metropolitan statistical average hospitals – peer group average – these hospitals are peer grouped on the basis of wage index categories – Out-of-state hospitals – Average cost per discharge that varies based on hospital type (teaching hospital, children's hospitals and all other).	
3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	• Indirect medical education (IME) costs are excluded from the average cost per case for purposes of comparing amounts to the 70th percentile amount for peer groups B and C (described earlier). IME costs are estimated using an IME ratio multiplied times the operating and capital components of the cost basis. The IME ratio is calculated using the following formula: (Interns and Residents/Number of Beds) x .579. The IME costs are added	• Ohio excludes direct and indirect medical education costs from its conversion factor calculation. • Ohio hospitals may receive a direct medical education allowance and an indirect medical education allowance, which Ohio adds to the DRG base price for teaching hospitals after multiplying the allowance by the DRG relative weight. • Ohio makes DSH payments separately from its DRG payments. DSH payments are not	• Direct medical education costs are reported separately in the Pennsylvania Medicaid cost report, and are excluded from the costs used to calculate conversion factors. Indirect medical education costs are not removed. • Pennsylvania makes separate quarterly DME payments. Payment amounts were originally cost-based, but have not been significantly modified for some time. • Pennsylvania makes DSH payments separately from its DRG payments. DSH

Task	Questions	Washington	Ohio	Pennsylvania
		back to the average cost per case after the 70th percentile is applied. • Direct Medical Education (DME) costs are included in the average cost per case for purposes of calculation conversion factors, and comparing average cost per case to the 70 percent cap. DME costs are identified through the cost report, Form CMS 2552, Worksheet B, Part I, (Column 26, Line 95). • DSH payments are not factored into the calculation of conversion factors.	factored into the calculation of conversion factors.	payments are not factored into the calculation of conversion factors.
3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	• Washington State Medicaid uses the cost-based conversion factor calculated at rebasing (inflated by the legislatively authorized inflation factor) as a ceiling in its negotiations with hospitals.	• Ohio does not use selective contracting.	• Pennsylvania does not use selective contracting.
3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	• For hospitals designated as border-area hospitals, Washington State Medicaid calculates conversion factors and RCCs using the same approach it applies to in-state hospitals. When no cost report is available, a border hospital receives	• No, although there are differences in conversion factor calculations between in-state and out-of-state hospitals. For out-of-state hospitals, average cost per discharge amounts for three peer groups are used (six peer groups are used for in-state hospitals,	• Border hospitals are not distinguished from other out-of-state hospitals. Out-of-state hospitals are generally reimbursed under the DRG system using a statewide average conversion factor. Out-of-state hospitals with more than 400 Pennsylvania Medicaid

Task	Questions	Washington	Ohio	Pennsylvania
		the peer group average conversion factor (adjusted by legislatively authorized inflation factors) and the average in-state RCC ratio. • Washington State Medicaid reimburses non-border area out-of-state hospitals by paying the lesser of billed charges or the weighted average in-state RCC multiplied by allowed charges. Medicaid calculates the weighed average in-state RCC annually in years when cost reports are available (see evaluation matrix for Border-Area Hospitals for additional discussion).	as discussed later in this matrix). Out-of-state peer groups are: – Teaching hospitals – Children's hospitals – All other hospitals	cases have hospital-specific conversion factors.
3	What method was used to establish relative weights?	• Washington State Medicaid determines AP-DRG relative weights using average charge per discharge amounts. • Medicaid establishes a single set of Medicaid-specific relative weights from Washington Medicaid fee-for-service and Healthy Options paid claims data spanning two hospital fiscal years. These relative weights may be stable or unstable.	• Ohio determines DRG relative weights using average charge per discharge amounts. • Ohio Medicaid uses the most recent two years of fee-for-service DRG claims data for calculating relative weights. • Ohio gives special consideration to psychiatric DRGs 425 and neonatal DRGs 385 to 390. Specifically: – DRG 386 (Extreme Immaturity or	• Pennsylvania determines DRG relative weights using average cost per discharge amounts. • The Department uses estimated costs the most recent fee-for-service paid claims data available for at least a two-year period. • The Department estimates the cost of each discharge using a detailed cost apportionment methodology (at the revenue code and cost center level of detail) using

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		– Medicaid staff statistically test each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards. – Medicaid tests the stability of the relative weights using a reasonable statistical test to determine if the weights are stable. Medicaid accepts as stable and adopts those relative weights that pass the reasonable statistical test. – Medicaid staff may compare the Medicaid-specific relative weights to non-Medicaid relative weights. This has been done in the past to establish proxy relative weights, but did not do so during the last recalibration. – During the last recalibration, Medicaid determined that DRGs with unstable relative weights (based on Medicaid data) would be paid based on the RCC methodology.	Respiratory Distress Syndrome): Ohio uses three subgroups with three different relative weights. These groups and relative weights are based on the ICD-9-CM codes and the level of the neonatal nursery. Ohio calculates the geometric mean charge per discharge for each of these subgroups for purposes of relative weight calculation – DRG 387 (Prematurity with Major Problems): Ohio uses four subgroups with four different relative weights. These groups and relative weights are based on the infant's birthweight and the level of the neonatal nursery. Ohio calculates the geometric mean charge per discharge for each of these subgroups for purposes of relative weight calculation. – DRGs 388, 389, 390: Ohio determines a geometric mean charge per discharge specific to hospitals with a level I nursery, hospitals with a level II nursery and one reflecting data from hospitals with a level III nursery.	data from the hospital's most recent cost report on file. • The following types of claims are excluded from relative weight calculations: – Distinct part psychiatric units excluded from the DRG payment system. – Distinct part drug and alcohol treatment units excluded from the DRG payment system. – Services previously paid as inpatient hospital services but which are no longer paid as inpatient claims. – DRGs 469 and 470. – Cross-overs – Patient transfers, except for transfers occurring in DRGs 385 and 456. – Distinct part medical rehabilitation units excluded from the DRG payment system. • The Department adjusts the cost of a claim by: – Computing a hospital -specific average

Task	Questions	Washington	Ohio	Pennsylvania
		• Medicaid adjusts all stable relative weights so that the average weight of the case mix population equals 1.0.	– DRGs 425 to 435: Ohio calculated two geometric mean charge per discharge amounts for each DRG. One geometric mean charge was calculated using the charge for each case within these DRGs from hospitals which have a psychiatric unit distinct part. A second geometric mean charge was calculated for each DRG 425 to 435 using data from all other hospitals (hospitals which do not have a recognized psychiatric unit distinct part under Medicare).	cost per case by dividing the total costs for claims in a hospital by the total number of claims for the hospital. – Computing a statewide average cost per case by dividing the total costs for all claims by the total number of claims. – Dividing the cost per case by the statewide average cost per case to determine a hospital specific standardization factor. – Multiplying the cost of a hospital's claim by its corresponding standardization factor. • The Department computes the relative value for each DRG by: – Determining the total standardized cost for all approved claims in the database. – Determining the total number of Medicaid hospital cases in the database. – Dividing the total standardized costs by the total number of cases to establish a statewide average cost per case for all cases.

Task	Questions	Washington	Ohio	Pennsylvania
				– Determining the total costs and total number of cases for each DRG. – Dividing the total costs for each DRG by the corresponding number of Medicaid cases for that DRG to establish an average cost per case for each DRG. – Dividing the average cost per case for each DRG by the statewide average cost per case for all cases to establish the relative value for each DRG used when available.
3	What is the methodology for rebasing/recalibrating the DRG system?	• See previous response.	• At the beginning of each State Fiscal Year, Ohio applies a projected inflation value. The Administrative Code also states that the State may choose to make a rules adjustment and rebase base-year costs or recalibrate the relative weights, or both. • If a reclassification of hospitals among peer groups occurs, Ohio will re-determine the peer group average cost per discharge component if such a re-determination will result in at least a two percent difference, negative or positive, in the peer group average cost per discharge amount.	• Please see the discussion of the calculation of relative weights above. • Relative weights for new DRGs that arise from the latest DRG Grouper are calculated based on Medicaid claims data.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – DRG Methodologies and Related Issues

Task	Questions	Washington	Ohio	Pennsylvania
3	How often are the AP-DRG relative weights recalibrated?	• Medicaid rebases the Medicaid payment system "periodically". • AP-DRG Version 14.1 DRGs and relative weights have been used since January 1, 2001.	• Rebasing is completed on an as-needed basis.	• DRGs 493 and higher are recalibrated annually based on Medicaid claims data. DRGs lower then 493 have not been recalibrated in several years.
3	How often are conversion factors rebased, updated, or recalculated?	• Washington State Medicaid may adjust all cost-based conversion factors by an inflation factor, only as authorized by the legislature. Medicaid does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program. • Washington Medicaid last updated conversion factors on July 1, 2005 based on vendor rate increases approved by the legislature.	• At the beginning of each State Fiscal Year, Ohio applies a projected inflation value. The Administrative Code also states that the state can apply an inflation adjustment, rebase base-year costs or recalibrate the relative weights, or any combination of these activities.	• Conversion factors have not been rebased since the release of the 86/87 Medicaid Cost Report. • Conversion factors are updated for inflation annually.
5	What is the payment policy when billed charges are less than DRG payment?	• Washington Medicaid pays the full AP-DRG payment amount regardless of whether such payments exceed billed charges.	• The Ohio Administrative Code does not mention this issue specifically. • Payments for DRG claims that include day outlier payments may not exceed allowable	• Payments are capped at charges.

Task	Questions	Washington	Ohio	Pennsylvania
			charges. • Payments for DRG claims that include cost outlier payments may not exceed the lower of claim cost or allowable charges.	
6	What methods are used to pay for transfer cases?	• A transfer occurs when a client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit: <u>Payment to Transferring Hospital and Intervening Hospital</u> • The transferring hospital is paid the lesser of the DRG payment, or a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. <u>Payment to Discharging Hospital</u> • Medicaid pays the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment and applies the outlier payment methodology if a transfer case qualifies as a high- or low-cost outlier.	• A transfer occurs when a patient is transferred from one hospital that is paid under the Medicaid prospective payment system to another hospital that is also paid under the Medicaid prospective payment system <u>Payment to Transferring Hospital</u> ▪ The transferring hospital is paid a per diem rate for each day of the patient's stay in the hospital, plus capital and teaching allowances, as applicable, not to exceed, for non-outlier cases, the final DRG rate that would have been paid ▪ If the case being transferred is classified DRG 385 (neo-natal transfer) or 456 (burn cases), the transferring hospital is paid the full DRG payment. <u>Payment to Discharging Hospital</u> ▪ The discharging hospital is paid a per diem	• A transfer occurs in those instances in which a patient is transferred between two hospitals, both of which are paid under the Medicaid prospective payment system. <u>Payment to Transferring Hospital</u> • Except as specified below, if an inpatient is transferred, the transferring hospital is paid the lesser of the per diem rate for each day of inpatient care and the hospital's DRG payment rate. • If the case being transferred is classified into DRG 385 or DRG 456, the transferring hospital is paid the full DRG rate. • A hospital transferring a patient is paid the full DRG rate only if the patient was admitted to the hospital by way of a transfer from the acute care setting of another hospital paid under the DRG payment system, or if the patient is classified into one

Task	Questions	Washington	Ohio	Pennsylvania
		• Medicaid does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back. Medicaid pays the intervening hospital(s) the transfer per diem rate described above. • Medicaid's maximum payment to the discharging hospital is the full DRG payment. <u>Calculation of Per Diem rate</u> • Medicaid determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average length of stay. The department uses the hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and Medicaid's length of stay data to determine the number of medically necessary days for a client's hospital stay.	rate for each day of the patient's stay in the discharging hospital, plus capital and teaching allowances, as applicable, not to exceed, for non-outlier cases, the final DRG rate for the DRG assigned by the transferring hospital. <u>Calculation of Per Diem Rate</u> ▪ Divide the applicable inflated average DRG payment by the statewide geometric mean length of stay calculated excluding outliers for the specific DRG into which the case falls.	of the DRGs from 386 through 390 or 457 through 460 inclusive. <u>Payment to Discharging Hospital</u> • The discharging hospital is paid the lesser of one of the following: – The DRG payment rate for the case, or – An amount determined by: ▪ Dividing the hospital's DRG payment rate by the Statewide average length of stay for the DRG. ▪ Multiplying the amount by the number of days in the hospital. ▪ Multiplying the amount by .60 to establish a marginal per diem payment amount for the hospital. <u>Calculation of per diem rate</u> • The per diem rate is determined by dividing the hospital's appropriate DRG payment rate for the case by the statewide average length of stay for the DRG. In computing the per diem payment, the day of transfer is a non-compensable day unless it is also the day of

Task	Questions	Washington	Ohio	Pennsylvania
				admission.
6	How are payments to specialty hospitals and long-term care hospitals made when patients are transferred from acute care hospitals?	• Not specified. It is assumed that payment methods do not deviate from the standard payment methodologies established for these settings if patients are received through a transfer from acute care settings.	• Not specified. It is assumed that payment methods do not deviate from the standard payment methodologies established for these settings if patients are received through a transfer from acute care settings.	• Not specified. It is assumed that payment methods do not deviate from the standard payment methodologies established for these settings if patients are received through a transfer from acute care settings
6	Is a hospital peer group conversion factor used? If so, how are the peer groups defined?	• There are six peer groups: – Group A, rural hospitals (EXEMPT FROM DRG) – Group B, urban hospitals without medical education programs (paid via DRG) – Group C, urban hospitals with medical education program (paid via DRG) – Group D, specialty hospitals or other hospitals not easily assignable to the other five groups (paid via DRG) – Group E, public hospitals	• Ohio calculates the conversion factor differently for different six types of hospitals as follows: – Children's hospitals --- 100 percent hospital-specific – Rural referral center hospitals – peer group average – Teaching hospitals – peer group average – Non-metropolitan statistical average area hospitals with less than 100 beds – peer group average – Non-metropolitan statistical average area hospitals 100 or more beds – peer	• See the discussion of conversion factors above.

Task	Questions	Washington	Ohio	Pennsylvania
		participating in the "full cost" public hospital certified public expenditure (CPE) program (EXEMPT FROM DRG). – Group F, critical access hospitals (EXEMPT FROM DRG)	group average – Metropolitan statistical average hospitals – peer group average – these hospitals are peer grouped on the basis of wage index categories – Out-of-state hospitals – Average cost per discharge that varies based on hospital type (teaching hospital, children's hospitals and all other).	
6	Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	• No. See the discussion of conversion factors above.	• No. See the discussion of conversion factors above..	• No. See the discussion of conversion factors above.

Table B: Strengths and Challenges of Selected States' DRG Methodologies

	Washington	Ohio	Pennsylvania
Strengths	• Conversion factor calculation considers type of hospital and other issues that can cause differences in costs. More opportunity to reward efficient hospitals. • Uses AP-DRG grouper, which is better than the Medicare DRG grouper because it was specifically designed to account for the Medicaid patient population with specific attention to neonatal care. • Cap on payments to urban hospitals limits the opportunities for high cost urban hospitals to obtain excessive payments.	• Conversion factor calculation considers type of hospital and other issues that can cause differences in costs. More opportunity to reward efficient hospitals. • Transfer payment methodology takes into consideration the increased intensity of costs in the first days of care for the transferring hospital by use of a geometric mean length-of-stay for determining the average per diem payment.	• Conversion factor calculation considers type of hospital and other issues that can cause differences in costs. More opportunity to reward efficient hospitals. • Uses cost-based relative weights rather than charge-based weights. Use of cost-based weights reduces distortions in weights that may be caused by hospitals with high mark-ups over cost, which may contribute a large number of cases to a specific DRG category.

	Washington	Ohio	Pennsylvania
Challenges	• Use of an older AP-DRG grouper means that new technologies and most current medical practices may not be adequately identified and may be paid inappropriately. • Pays GME on a per case basis which allows it to vary with volume, which means that a teaching hospital that experiences a decline in volume may not receive the full costs of graduate medical education and a teaching hospital that increases its volume may receive more than its costs for GME. • No consideration of geographic wage differences across state – use of urban and rural classifications do somewhat distinguish between wage rates in different communities, but some urban hospitals may be disadvantaged by lack of a geographic wage adjustment. • No specific plan for recalibration of weights. • The indirect medical education factor used to estimated indirect medical	• Pays GME on a per case basis which allows it to vary with volume, which means that a teaching hospital that experiences a decline in volume may not receive the full costs of graduate medical education and a teaching hospital that increases its volume may receive more than its costs for GME.	• Conversion factor calculation is hospital-specific, which means that there is less opportunity to reward efficient hospitals. Hospital can only gain if it improves its efficiency, which is difficult for an efficient hospital and easy for an inefficient hospital. The approach may reward inefficient hospitals and penalize efficient hospitals. • Infrequent recalibration and rebasing means that changes in technology and management initiatives of hospitals are not recognized in rates. • For transfer cases, the payment methodology does not reflect the higher intensity of costs in the first days of care for the transferring hospital.

	Washington	Ohio	Pennsylvania
	education costs is not based on the most current Medicare formula, which has been modified in recent years by Medicare. Cost estimations based on the older formula may be less predictive of related costs. • For transfer cases, the payment methodology does not reflect the higher intensity of costs in the first days of care for the transferring hospital.		

Table C: DRG Methodologies and Related Issues: Recommendations for Washington Medicaid

1. The State should update the version of the AP-DRG grouper that it is using. There are substantial improvements in the AP-DRG groupers developed after version 14.1. The most current version (version 21.0) should be implemented. In addition, the State should consider establishing a regular schedule for updating the AP-DRG grouper version, along with relative weights and conversion factors.
2. The State should bring as many services as possible into the DRG-based payment methodology. As discussed in following sections, the State pays for significant volumes of services using other payment methods, and many of these services can be appropriately paid under the DRG-based methodology. The State also excludes provider types from the DRG-based methodology that could also be paid appropriately using this methodology.
3. The State should reconsider the need to maintain peer groupings for purposes of establishing ceilings for payment purposes, and if necessary, evaluate peer grouping criteria to be consistent with other adopted methodology changes.
4. The State should also consider whether peer group or statewide conversion factors could replace the current facility-specific approach. If adopted, such an approach should also consider the necessary adjustments to reflect appropriate differences in costs between providers, such as regional differences in wages, the costs of maintaining trauma programs, the costs of supporting graduate medical education programs, the costs associated with providing specialized children's services and high-risk neonatal services, and others.
5. The State should consider modifying the indirect medical education factor used in cost calculations to reflect the most current Medicare-based formula.
6. The Department should consider adjusting the transfer-out payment policy to better reflect the higher intensity of costs in the first few days of a patient's stay. For example, the state should consider following Medicare's approach of adding an additional day of stay for purposes of calculating payment for the transferring hospital, or use 200 percent of the per diem for the first day.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix - Per Case and Per Diem Payment Methods

Table A: Comparison of Washington Medicaid and Two Highest Scoring States

Task	Questions	Washington	Virginia	Indiana	Medicare
4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology?* If so, for what services?	• Washington Medicaid does not use per diem payments for inpatient hospital acute care services. The State pays for services excluded from its AP-DRG methodology using a ratio of cost-to-charges (RCC) methodology.	• Virginia Medicaid pays for rehabilitation and psychiatric services outside of its DRG system using a per diem methodology.	• Indiana Medicaid pays for rehabilitation, psychiatric and certain burn services outside of its DRG system using a per diem methodology. • Indiana Medicaid refers to its per diem approach as a "level of care" approach with per diem payments for each of the following four levels of care: – Psychiatric – Burn 1 – Burn 2 – Rehabilitation • Based on an analysis of costs, Burn 1 rates are for services provided in certified burn care facilities (four statewide) that provide more intensive and more costly burn care than other Indiana hospitals.	• Medicare pays for psychiatric services and rehabilitation services outside of its DRG system using a per discharge and per diem approach, respectively.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix - Per Case and Per Diem Payment Methods

Task	Questions	Washington	Virginia	Indiana	Medicare
4	Describe the fixed payment per case or per diem methodology? How are payment levels determined?	• Not applicable – no fixed per diem or per case methodology used.	• Virginia pays for psychiatric and rehabilitation services using a statewide per diem payment, adjusted for regional wage variations. • For psychiatric and rehabilitation Services provided in an acute care setting, per diem rates are determined as follows: – Operating per diem rate – Virginia Medicaid calculates the per diem separately for psychiatric and rehabilitation services, and for State-owned teaching hospitals and all other hospitals. The per diem rate equals total estimated costs related to the service/hospital type divided by total days related to the service/hospital type. Virginia Medicaid adjusts this rate as follows: ▪ Multiplies the labor-related portion of this rate by Medicare's hospital wage index.	• Indiana uses the AP-DRG grouper to classify services into the DRGs that the State pays using per diems. The level of care-specific per diem encompasses operating and capital costs: – Operating costs (statewide rate) are determined on a per diem cost basis for each hospital by using cost-to-charge ratio adjusted claims data. Indiana Medicaid sets the per diem at the weighted median per diem cost. – Capital costs (statewide rate) are based on Indiana's DRG capital rate, adjusted to a per diem using the average length of stay for the assigned DRG with an occupancy adjustment. • Indiana Medicaid sets children's hospital payments at 120 percent of the statewide level of care rate. • Indiana Medicaid rebases its per diem rates periodically and updates	• For psychiatric hospitals or distinct part units, Medicare bases its system on a Federal per diem base rate comprised of labor and non-labor shares that are subject to five different patient characteristic adjustments: – Age – nine categories – 15 DRGs – Comorbidities – 17 possible groupings – Variable per diem factors to recognize the higher costs incurred in the early days of a stay. – Electroconvulsive Therapy – set dollar amount – Medicare's payments also include facility adjustments for teaching status, and urban versus rural location • Medicare has adopted a four-year transition period for psychiatric services during which hospitals'

Task	Questions	Washington	Virginia	Indiana	Medicare
			▪ Inflates the per diem using the DRI-Virginia moving average. ▪ Multiplies the per diem by an adjustment factor that standardizes cost coverage between State-owned teaching hospitals and all other hospitals. – Capital payment – determined on an allowable cost basis and settled at the hospital's fiscal year end. State-owned teaching hospitals receive 100 percent of allowable costs and all other hospitals receive 80 percent of allowable costs. • For services provided by freestanding psychiatric hospitals, per diem rates are determined as follows: – Operating per diem component is calculated the same as for acute care psychiatric and rehabilitation services. – Capital per diem component is	annually for inflation.	payments are based on a blend of the former cost-based payment and the new methodology. In addition, during the transition period, Medicare guarantees hospitals an average payment per case no less than 70 percent of their payment under the former payment system. • For rehabilitation hospitals and distinct part units, Medicare uses 100 distinct case-mix discharge groups. This method more closely resembles a DRG methodology, but is described here because of its unique application to rehabilitation services. Specifically, Medicare developed: – 95 case-mix discharge groups using rehabilitation impairment categories, functional status (both motor and cognitive) and age. – Five special case-mix groups to account for very short stays and patient who expire in the

Task	Questions	Washington	Virginia	Indiana	Medicare
			equal to a statewide capital rate adjusted by the Medicare geographic adjustment factor for the hospital's geographic area. The statewide capital rate is the weighted capital cost per diem of freestanding psychiatric facilities licensed as hospitals.		facility. • Medicare developed relative weighting factors for each of the case mix groups to account for a patient's clinical characteristics and anticipated resource needs. Medicare "tiered" these weighting factors within each case-mix group based on the estimated effects that certain comorbidities have on resource use. Medicare multiplies each weighting factor by its standardized base payment rate. • Medicare adjusts its standardized payment rate by hospital to account for: – Geographic variations in wages (wage index) – Percentage of low-income patients – Location in a rural area – Early transfer of a patient – Interrupted stays – High cost outliers

Task	Questions	Washington	Virginia	Indiana	Medicare
					– Coding adjustment – Teaching status
4	Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	• Not applicable – no fixed per diem or per case methodology used.	• No	• Burn cases may be paid outlier payments; payments equal 60 percent of the difference between estimated costs and the outlier threshold (two times the burn level of care payment amount).	• Under the psychiatric per diem methodology, Medicare provides outlier payments for discharges where estimated costs for the entire stay exceed an adjusted threshold amount ($4,200 multiplied by facility-specific adjustments) plus the total Medicare prospective payment amount for the stay. Medicare pays 80 percent of the difference between the estimated cost and threshold for days 1 through 8 of the stay, and 60 percent of the difference for day 9 and thereafter. • For the rehabilitation per discharge methodology, Medicare makes outlier payments for discharges if the estimated costs for a case exceed Medicare's payment plus the adjusted threshold amount ($5,129 in Federal Fiscal Year 2006). Medicare pays 80 percent of the difference between the threshold

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix - Per Case and Per Diem Payment Methods

Task	Questions	Washington	Virginia	Indiana	Medicare
					and the estimated cost.
4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs? (Note – comments are those received through the interview process).	• Not applicable – no fixed per case methodology used.	• Not applicable – no fixed per case methodology used.	• Not applicable – no fixed per case methodology used.	• There is no apparent advantage to a fixed payment per case or discharge compared to payment under a DRG methodology. Under a true fixed payment per case methodology, an outlier payment would not be made, however, in this instance, an outlier payment is made for qualifying rehabilitation cases.
4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs? (Note – comments are those received through the interview process).	• Not applicable – no fixed per diem methodology used.	• Not discussed with the State.	• The per diem methodology addresses services that have wide variances in length of stay or resource consumption.	• Using a per diem approach allows for more a more precise measurement of the costs incurred to provide rehabilitation services, as compared to DRGs.

* *Note: While none of the surveyed states used a per case payment approach, Wyoming Medicaid uses a level of care all-inclusive payment per discharge methodology for inpatient acute care services. Wyoming Medicaid's methodology uses nine levels of care determined by diagnosis, procedure and revenue code. Wyoming Medicaid inflates its hospital-specific rates annually, and uses an outlier payment policy. NCI is not recommending this approach to Washington Medicaid as the State's current DRG system allows for a greater degree of variation in payments according to the resources needed for a particular services.*

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	Virginia	Indiana	Medicare
Strengths	• Washington Medicaid's AP-DRG per discharge system, in contrast to a per diem system, provides increased incentives for hospitals to provide care efficiently and reduce lengths of stay, since hospitals retain the difference between reported costs and payments. • Administratively less burdensome, because there is no need for length of stay review.	• Accounts for patient acuity to some degree by paying for longer lengths of stay. • Offers the Commonwealth some predictability of and control over expenditures due to the prospective nature of the per diem approach, in contrast to payment based on a percent of charges. • Recognizes differences in labor costs across the Commonwealth. • Adjusts for hospital-specific experience by varying payment calculations by hospital type and geographic region.	• Accounts to some degree for patient acuity by paying for longer lengths of stay. • Offers the State some predictability of and control over expenditures due to the prospective nature of the per diem approach, in contrast to payment based on a percent of charges. • Provides an incentive for hospitals to control their costs (even for hospitals whose costs are below the average) by limiting payments for operating costs to the median cost per day. • Differentiates between intensity of care within burn services. • Allows for additional payments for some burn services requiring intensive resources ("outlier" payments).	• Addresses reported shortcomings of DRGs that indicate that the DRG classification system does not adequately differentiate rehabilitation diagnoses and psychiatric diseases and disorders in terms of the resources needed to treat them on a per case basis. • Accounts for patient characteristics that can affect length of stay and cost per day. • Based on data that is currently available on claims, so there are no changes in claims submission requirements. • Does not require changes in coding requirements. • Any hospital that provides services to Medicare patients has experience, albeit limited, with the system. • Accounts for rehabilitation-specific and psychiatric-specific patient acuity. • Offers Medicare some predictability and control over expenditures due

	Washington	Virginia	Indiana	Medicare
				to the prospective nature of the per diem and per discharges approaches. • Accounts for differences in provider costs by including, for example, geographic region and teaching adjustment factors.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix - Per Case and Per Diem Payment Methods

	Washington	Virginia	Indiana	Medicare
Challenges	• RCC-based payment does not provide an incentive for cost effectiveness, and does not offer the State predictability of or control over its expenditures. • Reflects individual hospitals' cost experiences, thus hospitals do not have incentives to limit the services they provide to those that are reasonable and necessary. • Does not provide hospitals with an incentive to control length of stay, so utilization review is necessary to assure that all inpatient days are medically necessary. • Hospitals can directly affect their payments by increasing charges for services. Under this scenario, the State has limited control over its expenditures.	• Does not provide hospitals with an incentive to control length of stay, so utilization review is necessary to assure that all inpatient days are medically necessary. • May not reflect individual hospitals' cost-specific experiences as per diems do not vary according to each hospital's individual costs. • Does not account for variances in patient acuity on a per day basis as Medicare does with its various adjustments to its psychiatric per diem payments. • Does not provide additional payments for extraordinarily higher cost services ("outliers").	• Does not account for patient acuity differences that affect resource utilization per day. • Does not provide hospitals with an incentive to control length of stay, so utilization review is necessary to assure that all inpatient days are medically necessary. • Does not account for variances in patient acuity on a per day basis as Medicare does with its various adjustments to its psychiatric per diem payments.	• The psychiatric per diem methodology is very new (implemented January 1, 2005), so its impact is not yet known. • The rehabilitation per discharge methodology is potentially administratively burdensome to administer, requiring frequent updates and recalibration of relative weights.

Table C: Per Case and Per Diem Payment Methods: Recommendations for Washington Medicaid

1. Overall, the State should consider transitioning from its RCC payment approach and move to a prospective per discharge or per diem payment methodology for services currently paid under the RCC method.
2. The State should consider a per diem approach for payment of psychiatric services, rehabilitation services, and acute services that are categorized into AP-DRGs that do not have enough historical claims volume to support the calculation of stable relative weights. The State should analyze the costs of providing psychiatric and rehabilitation services in freestanding psychiatric and rehabilitation hospitals, distinct part units and in acute care hospitals without distinct part units to identify variations and evaluate whether the variations should be accounted for in the per diem payment methodology.
3. For new per diem services, the State should consider the need for a cost outlier policy. The State should conduct analyses during Phase 2 of the project to determine the significance of potential outliers.
4. If the per diem methodology is expanded to more services, the State should consider implementation of concurrent utilization review and limitations on cost components (consistent with those adopted for the AP-DRG methodology, if applicable).
5. If the per diem methodology is expanded to more services, the State should consider adjusting the costs used for setting AP-DRG conversion factors to exclude the costs of services to be paid under the per diem methodology.
6. The State should consider establishing a consistent schedule for adjusting per diem rates to take into consideration price level increases, and for rebasing per diem rates.
7. Please refer to the discussion regarding psychiatric services evaluation for additional recommendations regarding the adoption of a per diem approach for psychiatric services. Also, please refer to the discussion regarding centers of excellence for more discussion of payment alternatives for transplant services.

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Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – RCC Payment Methodology

Table A: Comparison of Washington Medicaid and Two Highest Scoring States

Task	Questions	Washington	Indiana	Ohio
3	Describe methods of reimbursement for inpatient services that use an RCC methodology?	• Washington State Medicaid pays for a portion of Medicaid inpatient services using an RCC methodology. The RCC methodology is used for all services provided by specific hospital types, and for specific services provided by all hospitals. • The following hospital types are paid based on the RCC methodology: – Rural Hospitals (peer group A) – Rehabilitation units when the services are provided in Medicaid-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals. – Non state-owned specifically identified psychiatric hospitals and designated hospitals with Medicare certified distinct psychiatric units. Washington Medicaid uses the Medicare program criteria to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.	• Not applicable. ***Note that Ohio is the only state in core state sample that uses RCCs for payment, with the exception of Oregon, which uses RCCs on an interim basis for Critical Access Hospital payments (which are cost-settled). Indiana was selected because its methods are similar to all other core states other than Ohio.***	• Ohio pays for inpatient hospitals using DRGs with the exception of certain providers/services, which it pays on a reasonable cost basis using RCCs, as described below.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – RCC Payment Methodology

Task	Questions	Washington	Indiana	Ohio
3	For what services is the RCC methodology used?	• The following services are paid via RCC: – Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641. – Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. – Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with Medicaid to perform these services. – Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically dependent pregnant women (CUP program) by a certified hospital. – Acute physical medicine and rehabilitation services provided in Medicaid-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. – Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, or	• An RCC is used only for the determination of outlier payments.	• The following services are paid via RCC: – Freestanding rehabilitation hospitals excluded from Medicare PPS – Freestanding long-term hospitals excluded from Medicare PPS – Hospitals providing rehab and long-term care services that are excluded from Medicare PPS – Ohio hospitals that are owned and operated by health insuring corporations licensed by the Ohio Department of Insurance and which limit services to Medicaid recipients – Cancer hospitals – Selected transplant services – heart/lung and pancreas, liver/small bowel – Outliers

Task	Questions	Washington	Indiana	Ohio
		simultaneous kidney/pancreas (see discussion in the Centers of Excellence Evaluation Matrix).		
3	How are RCCs calculated? What are the data sources that support the calculation?	• Washington State Medicaid calculates RCCs using data extracted from the Medicare cost report, Form CMS 2552, which is submitted to CMS annually. Medicaid extracts cost and charge information from the cost report, and divides costs by charges to determine the RCC for each hospital. Costs and charges used for the RCC calculations are described in more detail below: – For each hospital's costs, Medicaid adds direct medical education costs reported on Worksheet B, Part 1, (Column 26, line 95), to allowable operating costs reported on Worksheet C (Column 5, line 103). – For each hospital's charges, Medicaid extracts patient revenue amounts from Worksheet G-2 (Column 3, line 25), but removes from its calculation hospital-based physician revenues shown as a qualifying adjustment on Worksheet A-8-2 (Column 4) and other revenues considered unallowable by Medicaid. – Increases in operating costs or total rate-	• For outlier cases only, Indiana calculates all-payer RCCs using provider cost reports. RCCs are determined only during rebasing and recalibration periods. The statewide median cost-to-charge ratio is applied to new in-state or border hospitals until a Medicaid cost report is received and audited.	• Ohio calculates all-payer RCCs based on data from each hospital's cost report filed during the calendar year proceeding the year during which the prospective rate year began.

Task	Questions	Washington	Indiana	Ohio
		setting revenue attributable to change in ownerships are excluded. • Medicaid calculates payments by multiplying the hospital RCC rate by allowed charges. All RCC payments are limited to 100 percent of allowable charges. • In-state hospitals without sufficient Medicare cost report data to calculate a hospital-specific RCC are reimbursed using the weighted average in-state RCC for inpatient services. Medicaid calculates the weighted average in-state RCC annually by dividing total allowable operating costs by total respective patient revenues.		
3	How often are RCCs recalculated or updated?	• The hospital-specific RCC is updated annually in years when Medicare Cost Reports are available. • CMS revised the cost reporting process, which delayed filing of cost reports by most hospitals for hospital fiscal years ending in calendar year 2000, 2001 and 2002 until late in calendar year 2002 and thru mid 2003. As a result, Washington State Medicaid did not set RCCs for most hospitals until calendar year 2003.	• Cost-to-charge ratios are calculated only during rebasing and recalibration periods, except for new providers.	• Annually.
3	Are routine care costs and charges used in calculating	• Yes. As described previously, the cost and charge source data for the RCC calculation	• Yes. Routine costs are a component of the	• Yes. Routine costs are a component of the RCC,

Task	Questions	Washington	Indiana	Ohio
	the cost to charge ratio? How are they incorporated into the RCC calculation or payment methodology?	includes routine costs and charges.	RCC, as extracted from the cost report.	as extracted from the cost report.
3	Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	• Washington State Medicaid limits payment for private room accommodations to the semi-private room rate. Room charges cannot exceed the hospital's usual and customary charges to the general public.	• Not applicable, because a facility-wide RCC is calculated.	• No mention in Ohio Administrative Code.
3, 9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	• The RCCs used to pay Critical Access Hospitals are updated annually.	• See discussion of CAHs.	• Not applicable.

Table B: Strengths and Challenges of Selected States' RCC Methodologies

	Washington	Indiana	Ohio
Strengths	• Recognizes characteristics of individual hospitals and allows for adjustments in payments based on those characteristics.	• Limits the use of RCCs to outliers; relies more on per diems that RCCs for services it deems to be necessary to exclude from DRGs.	• Compared to Washington, uses RCCs in more limited way.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – RCC Payment Methodology

	Washington	Indiana	Ohio
Challenges	• Broad use of RCCs compared to other states, takes away some of the predictability of the system for both hospitals and the Medicaid program. • Use of hospital-wide RCC rather than departmental RCCs results in an approximate calculation, which could be made more precise if departmental RCCs were used. This approach has no impact system wide if the method is budget neutral, but it would affect payments to individual hospitals. • Use of RCCs generally provides little incentive for hospitals to contain costs. • The methodology used to calculate RCCs is based on all-payer cost and charge data, which may result in RCCs that are not predictive of the costs to provide services to the Medicaid population. • The State performs RCC calculations each quarter (once each year for each hospital, but at different times each year depending on the hospitals' fiscal year ends). This approach is administratively burdensome.	• When RCCs are used (outliers only), Indiana uses hospital-wide rather than departmental RCCs, which results in an approximate calculation which could be made more precise if departmental RCCs were used.	• Uses hospital-wide RCC rather than departmental RCCs, which results in an approximate calculation which could be made more precise if departmental RCCs were used.

Table C: RCC Payment Methodology: Recommendations for Washington Medicaid

1. 1. The State should consider eliminating the use of RCCs in most cases. Many services currently paid based on the RCC methodology could be paid based on the AP-DRG methodology, or a per diem methodology. Such a change would result in greater incentives for cost effectiveness, and enhance predictability of expenditures for the State.
2. If RCCs are to be continued, the State should consider the use of departmental RCCs as opposed to aggregate RCCs, and adjust RCCs to be Medicaid-specific.
3. The State should consider calculating RCCs once each year, for all hospitals.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – High Cost Outlier Policy

Table A: Comparison of Washington Medicaid and Two Highest Scoring States

Task	Questions	Washington	North Carolina	Virginia
6	What is the AP-DRG or DRG outlier payment policy/methodology?	• Washington State Medicaid recognizes both cost outliers (high cost and low cost) and day outliers. Cost and day outliers are described separately in the following paragraphs: <u>Cost Outliers</u> • High-cost outlier payments are made in addition to the standard DRG payment for AP-DRG claims with extraordinarily high costs when compared to other cases in the same AP-DRG. An AP-DRG claim qualifies as a high-cost outlier if the allowable charges exceed an outlier threshold, which is three times the applicable AP-DRG payment and $33,000. • The outlier payment portion depends on the hospital type: – For non-psych services and non-children's hospitals, the outlier payment equals 75 percent of the allowed charges above the outlier threshold multiplied by the hospital's RCC rate. – Children's hospitals are paid 85 percent of allowed charges above the outlier	• North Carolina Medicaid recognizes cost outliers and for patients under six only, day outliers. Cost and day outliers are discussed separately in the following paragraphs: <u>Cost Outliers</u> • A cost outlier threshold is set for each DRG at the time DRG relative weights are calculated, using the same information used to establish those relative weights. The cost threshold is the greater of $25,000 or mean cost for the DRG plus 1.96 standard deviations. • Allowed charges are converted to cost using a hospital-specific total facility RCC. The RCC excludes medical education costs. • The cost outlier payment is 75 percent of the costs above the threshold as calculated on an individual claim by multiplying allowable charges by the hospital-specific inpatient total facility RCC. <u>Day Outliers</u> • Day outlier payments apply only for children under six at DSHs and children under age one at non-DSHs.	• Virginia Medicaid recognizes cost outliers only. • The hospital's outlier operating threshold for the case is equal to the wage-adjusted outlier operating fixed loss threshold times the adjustment factor, plus the hospital's operating payment for the case • The hospital's outlier operating payment for the case is equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment is made. If the difference is greater than zero, then the outlier operating payment is equal to the difference times the outlier adjustment factor. • Eligibility for an outlier operating payment and the subsequent amount are determined as follows: – The hospital's adjusted operating cost is estimated as the hospital's total charges for the case times the hospital's operating cost-to-charge

Task	Questions	Washington	North Carolina	Virginia
		threshold multiplied by the hospital's RCC rate. – Psychiatric services paid via DRG for AP-DRGs 424-432 are paid 100 percent of allowed charges above the threshold multiplied by the hospital's RCC rate. • High-cost outlier claims are paid from an individual hospital's outlier "set-aside" pool based on its prior high-cost outlier experience. Medicaid determines the projected outlier payment portions based on paid claims data from the base year used for the rebasing of the cost-based conversion factor. Medicaid then divides the aggregate outlier payment portions by Medicaid's total projected annual AP-DRG payments to the hospital. This results in a hospital-specific high-cost outlier percentage, referred to as the "outlier set-aside factor". • Medicaid reduces a hospital-specific conversion factor by an amount that goes into its set-aside pool to pay for all high-cost outlier cases during the year. No cost settlements are made to hospitals for outlier cases. • To qualify as a DRG low-cost outlier, the	• A day outlier threshold is set for each DRG at the time DRG relative weights are calculated, using the same information used to establish the relative weights. The day outlier threshold is the greater of 30 days or the arithmetical mean LOS for the DRG plus 1.5 standard deviations. • Days beyond the outlier threshold are paid at a per diem rate that is 75 percent of the hospital's DRG payment rate divided by the DRG average LOS. • Discharges that qualify for both cost outlier and day outlier payments are paid the greater of the cost outlier or day outlier payment.	ratio. – The adjusted outlier operating fixed loss threshold is calculated as follows: ▪ The outlier operating fixed loss threshold is multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. The non-labor portion of the outlier operating fixed loss threshold constitutes one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold. ▪ The labor portion of the outlier operating fixed loss threshold is multiplied by the hospital's Medicare wage index, yielding the wage-adjusted labor portion of the outlier operating fixed loss threshold. ▪ The wage-adjusted labor portion of the outlier operating fixed loss threshold is added to the non-labor portion of the outlier

Task	Questions	Washington	North Carolina	Virginia
		allowed charges for the case must be equal to or less than the greater of 10 percent or the applicable DRG payment or $450. • Washington Medicaid determines payment for a Medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate. <u>Day Outliers</u> • Washington Medicaid makes day outlier payments to hospitals for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for the day outlier payment if it meets all of the following criteria: – The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one; – The payment methodology for the admission is DRG; – The allowed charges for the hospitalization are less than the DRG		operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold. – The outlier operating fixed loss threshold is recalculated using base year data when the DRG payment system is recalibrated and rebased. The resulting threshold for outlier operating payments equal is to 5.1% of total operating payments, including outlier operating payments, for DRG cases.

Task	Questions	Washington	North Carolina	Virginia
		high-cost outlier threshold; and – The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. • Day outlier thresholds are defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days. • Washington Medicaid bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate. The Medicaid all-inclusive administrative day rate covers days of hospital stay in which a client no longer needs an acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available. The Administrative Day Rate is equal to the statewide average Medicaid nursing facility per diem rate. The administrative day rate is adjusted annually. Ancillary services provided during administrative days are not reimbursed. • Medicaid's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days		

Task	Questions	Washington	North Carolina	Virginia
		payment.		
	How often is the high outlier payment policy updated?	• The WAC does not specify a schedule for updating the outlier payment policy. The current high outlier payment policy is in effect for all discharges after January 1, 2001. • Cost outlier payments are based on the hospital-specific RCC, which is updated annually.	• Annually effective each October 1	• Every 3 years when rebasing occurs. Annual updates are made to account for inflation.
	Are conversion factors and the high outlier policy updated concurrently?	• The WAC states that the Medicaid payment system is rebased "periodically". It does not specify that conversion factors and the high outlier payment policy are to be updated concurrently.	• Yes. In years when the DRG unit value/conversion factor is updated for inflation.	• Every 3 years when rebasing occurs. Annual updates are made to account for inflation.
6	How are expected outlier payments considered or factored into the determination of conversion factors?	• Washington Medicaid removes the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap. • After an individual hospital's base period costs and its peer group cost cap are determined, Medicaid adds the individual hospital's indirect medical education costs and an outlier cost adjustment back to: – The lesser of the hospital's calculated	• In determining the original DRG unit value or conversion factor, the State reduced each hospital's case-mix adjusted cost per discharge by 7.2 percent to account for outlier payments. These DRG unit values have not been rebased since they were originally calculated, but are updated in some years for inflation.	

Task	Questions	Washington	North Carolina	Virginia
		aggregate cost; or – The peer group's seventieth percentile cost cap. • The outlier cost adjustment reduces the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process. The adjustment is calculated as follows: – If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back. – A reduced high-cost outlier amount is added back if: ▪ The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and ▪ The hospital is capped at the seventieth percentile. ▪ The outlier amount added back is determined by multiplying the original high-cost outlier amount by		

Task	Questions	Washington	North Carolina	Virginia
		the following ratio: Hospital final cost cap (the peer group's seventieth percentile cost) divided by the uncapped base period costs. • Washington Medicaid pays high-cost outlier claims from the outlier set-aside pool. Medicaid calculates an individual hospital's high-cost outlier set-aside as follows: – For each hospital, the department extracts Medicaid utilization and paid claims data from the Medicaid Management Information System (MMIS), Health Options data and CHARS data for the 12-month rebasing base year period (which was CY1998 for the most recent rebasing). – Using these paid claims data, Medicaid determines the projected annual amount above the high-cost DRG outlier threshold that is paid to each hospital. – The projected high-cost outlier payment to the hospital is divided by the total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This		

Task	Questions	Washington	North Carolina	Virginia
		percentage becomes the hospital's outlier set-aside factor. (For the last rebasing, most outlier set-aside percentages were hospital specific, but in some instances, proxies were used based on peer group averages.) • Medicaid uses the individual hospital's outlier set-aside factor to reduce the hospital's conversion factor by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. Medicaid funds the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements are made to hospitals for outlier cases.		
6	What proportion of cases are paid using the outlier methodology?	• 6.1 percent for SFY 2004.	• 8.5 percent	• A very small number, but unsure of actual percentage.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – High Cost Outlier Policy

Task	Questions	Washington	North Carolina	Virginia
6	Are there interim outlier payment strategies? What are they?	• High cost outlier interim payments are made when a patient's covered charges exceed the high cost outlier threshold, and the patient has not yet been discharged. The initial outlier interim payment, which is generated automatically, equals the AP-DRG payment plus the hospital billed covered charges above the high cost outlier threshold multiplied by the AP-DRG high cost outlier ratio. Subsequent interim payments, which are issued manually, equal the incremental billed covered charge amount multiplied by the AP-DRG high cost outlier ratio.	• Outlier payments can be made on interim bills that hospitals submit to the State's fiscal agent; when the hospital submits a final bill, there is a settlement to what the outlier payments should be.	• No.

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	North Carolina	Virginia
Strengths	• Outlier payment rates vary across provider types. Therefore, outlier payments take into account the characteristics of each hospital type • Provides control over total payments	• Frequency of updates to policy/methodology (annually) addresses changes in inpatient utilization over time.	• Outlier threshold calculation includes operating, labor, and wage adjustments, thereby reflecting the cost differences of individual hospitals.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – High Cost Outlier Policy

	Washington	North Carolina	Virginia
Challenges	• Infrequent updates to outlier policy/methodology does not address changes in inpatient utilization over time. • Calculation of outlier set aside adds more administrative complexity to the ratesetting program • Builds in past inefficiencies of hospitals thru the use of hospital-specific pools; similarly, does not take into account the needs of individual hospitals whose case-load might change from year to year (e.g., a hospital might have a few very high cost outliers and there is no mechanism to recognize those costs if they are a higher percentage of costs than in previous years). • Use of a hospital all-payer RCC for estimating costs may not reflect the costs of providing care to the Medicaid population. • The outlier set aside approach may create incentives to increase outliers if the set aside pool is not spent. • Using charges as a basis for comparison to the outlier threshold tends to increase outlier payments over time if hospital charges are increased. This approach also has the effect of increasing the set aside amount over time. •	• Outlier methodology does not take into consideration the variation in costs between hospital types.	• Infrequency of updates to policy/methodology (every 3 years) does not address changes in inpatient utilization between updates. • No low cost outlier policy • Since State cannot provide the percent of payments that are outlier, we cannot determine if set aside is reasonable or not

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – High Cost Outlier Policy

Table C: High Cost Outlier Policy: Recommendations for Washington Medicaid

1. The State should consider eliminating the day outlier policy. If hospitals do not incur additional costs for outlier cases, normally, there is no need to pay for long lengths-of-stay[1].
2. As discussed previously, the State should consider adopting a regular interval for updating the high-cost outlier threshold. There is also a need to regularly review the outlier policy to determine whether it is effective. Updates to the outlier policy could be made coincident with updates to conversion factors.
3. The State should consider implementing a policy where the outlier threshold is set at a level so that only those cases with extraordinarily high cost are identified as outlier cases. This policy should be reevaluated on an annual basis.
4. The State should consider implementing a policy where the outlier threshold is set at a level that results in a targeted outlier payment percentage of AP-DRG based payments, similar to CMS's policy for Medicare outlier payments. The threshold policy should be reevaluated on an annual basis so that resulting outlier payments remain within the States targeted amount.
5. The basis for outlier payments should be revised so that outliers are identified based on estimated costs, and outlier payments are based on a percentage of estimated costs that exceed the outlier threshold (estimated costs determined by multiplying the RCC by the billed allowed charges). Under the current methodology, outliers are identified based on charges and outlier payments are based on a percentage of the billed allowed charges that exceed the outlier threshold. This leads to increases in outlier payments when a hospital increases its charges.
6. The State should consider eliminating the facility-specific outlier set-aside amount. While it is important to consider and adjust the cost basis for conversion factors to reflect the costs of outlier claims, such adjustments could be accomplished at the statewide or peer group level. If the set-aside amount is retained, the calculation of the cost outlier set-aside amount should be modified to be consistent with revisions to the outlier payment policy. As described above, under the current policy, increases in charges tend to increase the outlier payments disproportionately. As a result, the set-aside amount tends to increase, thereby lowering the conversion factor, which in turn tends to further reduce the outlier threshold and increase outlier payments even more. The current methodology leads to ever-increasing levels of outlier payments.

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[1] Some states have maintained a day outlier policy for children's services to meet OBRA requirements. However, other states have successfully demonstrated that the use of cost outliers is sufficient to meet OBRA requirements without a separate day outlier policy.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – Critical Access Hospitals

Table A: Comparison of Washington Medicaid and Two Highest Scoring States

Task	Questions	Washington	Wisconsin	Ohio
3, 9	What method does the state use to identify CAH hospitals?	• All states use Medicare's CAH definition		
3, 9	How does the state pay for inpatient CAH services?	• Washington Medicaid uses retrospective cost settlement with interim payments based on hospital-specific departmental weighted cost-to-charges (DWCC) rates. Washington Medicaid performs: – Interim retrospective cost settlement for each CAH after the end of the CAH's fiscal year, using Medicare cost report data and claims data from the MMIS related to fee-for-services claims – Final cost settlement using the hospital's settled Medicare cost report instead of the initial cost report. *Note: State regulations (WAC 388-550-2598(12)) specify that managed care plans having contractual relationships with CAHs pay the inpatient and outpatient DWCC rates applicable to managed care claims. Washington Medicaid does not perform cost settlements for managed care claims.*	• Wisconsin Medicaid pays CAHs based on DRGs, with cost settlement to cover any outstanding Medicaid shortfall. If DRG payments exceed costs, Wisconsin Medicaid does not recoup payment. State staff indicated that Wisconsin will likely move to a percentage of charges interim payment approach in 2007. • Wisconsin Medicaid performs cost settlement using the hospital's audited Medicare cost report for dates of service being analyzed (two to four year lag period historically). The State applies the cost-to-charge ratios from the cost report for each cost center to the charges on the claims data to calculate hospital costs. • Wisconsin Medicaid will perform an interim cost settlement upon (1)	• Ohio Medicaid pays CAHs using DRGs and provides additional DSH payments that are based on a portion of a CAH DSH pool of $4,000,000.

Task	Questions	Washington	Wisconsin	Ohio
			a hospital's request, or (2) upon the State's identification of a large overpayment. The State uses the as-filed Medicare cost report for the dates of service in question to perform interim cost settlement.	

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	Wisconsin	Ohio
Strengths	• Retrospective cost settlement allows for rural and remote hospitals with diseconomies of scale to cover their costs and continue serving Medicaid recipients, thus promoting access to care. • Cost settlements and interim payments use detailed hospital cost information, thus reflecting individual hospital's cost experiences. »	• Retrospective cost settlement allows for rural and remote hospitals with diseconomies of scale to cover their costs and continue serving Medicaid recipients, thus promoting access to care. • Making DRG-based payments requires hospitals to follow the same billing and coding requirements as other hospitals, thus promoting coding accuracy, consistency and efficiency. • Cost settlements use detailed hospital cost information, thus reflecting individual hospitals' cost experiences.	• Making DRG-based payments requires hospitals to follow the same billing and coding requirements as other hospitals, thus promoting coding accuracy, consistency and efficiency. • Supplemental DSH payments allow CAHs to cover a portion of their Medicaid shortfall, thus recognizing the diseconomies of scale often experienced by rural and remote hospitals and achieving (at least to some extent) the same effect as cost reimbursement.

	Washington	Wisconsin	Ohio
Challenges	• Because payments are not based on DRGs, accurate claim coding (other than charge information) does not necessarily affect reimbursement. As such, even though providers are required to accurately code diagnosis codes and procedure codes, there may be less incentive for the coding to be as accurate as it would be if the claims were paid based on a DRG assignment. • Performing interim and final cost settlements (instead of one final settlement) increases Washington Medicaid's administrative burden; that burden may be appropriate given that it may take up to three or four years for a cost report to be settled. • Allowing for full payment of costs through retrospective cost settlement decreases the payment equity between CAHs and hospitals not designated as CAHs, however, this may be tolerable given the overriding objective to maintain access to services.	• Performing retrospective cost settlements increases Wisconsin Medicaid's administrative burden. • Allowing for full payment of costs through retrospective cost settlement decreases the payment equity between CAHs and hospitals not designated as CAHs.	• Hospitals in remote and rural areas with diseconomies of scale may not receive payment for all of their costs, creating potential access to care concerns.

Table C: Critical Access Hospitals: Recommendations for Washington Medicaid

1. The State should streamline the cost settlement process, and perform only one cost settlement. The current RCC methodology, if retained, should provide for sufficient reimbursement on an interim basis, until a final settlement can be completed.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Border Hospital Payment Methodology

Table A: Comparison of Washington Medicaid and Two Highest Scoring States

Task	Questions	Washington	Oregon	New Jersey
3	What criteria are used to identify border hospitals?	• Washington Medicaid defines "Border" hospitals as out-of-state hospitals in the following cities: – Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho – Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.	• Oregon defines border hospitals as Contiguous area hospitals that are out-of-state hospitals located less than 75 miles outside the Oregon border. • Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border.	• New Jersey defines border hospitals based on proximity to New Jersey and volume of New Jersey Medicaid activity at hospital. New Jersey seeks to minimize the number of border hospitals.
3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	• Washington Medicaid calculates border area hospital conversion factors and RCCs using the same approach it applies to in-state hospitals. When no Medicaid CMS Form 2552 cost report is available, a border hospital receives the peer group average conversion factor and the average in-state RCC ratio. • Washington Medicaid reimburses non-border area out-of-state hospitals by paying the lesser of billed charges or the weighted average in-state RCC multiplied by allowed charges. Washington Medicaid calculates the weighed average in-state RCC rate annually as described in the Evaluation Matrix for the RCC payment methodology.	• Contiguous area out-of-state hospitals, unless they have an agreement or contract with the State for specialized services, are paid the lesser of DRG reimbursement or billed charges. The conversion factor for contiguous out-of-state hospitals is set at the final unit value for the 50th percentile of Oregon hospitals. Contiguous area out-of-state hospitals are also eligible for cost outlier payments, but not capital or medical education payments. • Non-contiguous area hospitals are paid the same as contiguous out-of-state hospitals unless they have a contract for specialized services. They are not, however, eligible to receive cost outlier payments.	• New Jersey pays border hospitals the same DRG rate that is paid to in-state hospitals, based on type of hospital. The largest border hospital provider is Children's Hospital of Pennsylvania, which is paid the same rates as in-state hospitals, based on DRGs.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Border Hospital Payment Methodology

Task	Questions	Washington	Oregon	New Jersey
3	If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	• No. The payment methods used to pay border hospitals are the same as in-state hospitals. Border hospitals are not paid a discounted rate.	• Yes. See discussion above regarding no payment for capital and medical education costs, and outliers.	• No. Payments to border hospitals are not discounted.
3	Are any border hospitals reimbursed based on RCC methodologies?	• Yes. Washington Medicaid pays border hospitals using the same methodology as in-state hospitals, including the RCC methodology when applicable.	• No.	• No.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Border Hospital Payment Methodology

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	Oregon	New Jersey
Strengths	• Pays border hospitals on the same basis as in-state hospitals, promoting access to needed services by Washington State Medicaid beneficiaries. • Similarity to in-state payment methodology provides for better predictability of payments.	• Similarity to in-state payment methodology (with exceptions) provides for better predictability of payments.	• Pays border hospitals on the same basis as in-state hospitals, which promotes access for Medicaid beneficiaries. • Similarity to in-state payment methodology provides for better predictability of payments.
Challenges	• The different payment methods for border hospitals versus all other out-of-state providers may be considered inequitable. • Payments to non-border out-of-state providers may exceed payments to some in-state hospitals for the same services.		

Table C: Border Hospital Recommendations for Washington Medicaid

1. The State should re-evaluate the appropriateness of border hospital definitions, considering the access needs of Washington Medicaid clients relative to the provider services available in state, and those specific out-of-state hospitals that will enhance overall access to services.
   - For those hospitals identified as critical border-area hospitals in the above recommendation, maintain current policy of payment based on the methodologies used to pay in-state providers.
   - For those hospitals identified as non-critical border-area hospitals, consider simplifying the payment methodology to make payments based on the same method used for in-state hospitals, using averages of in-state providers' rates (average conversion factors or per diem rates, which could be based on peer group designations, and average RCC for outlier payment determination).
2. For both non-critical and non-border-state hospitals, consider exclusion of payments related to medical education costs (direct and indirect).
3. For out-of-state hospitals, consider exclusion of DSH payments. As part of the evaluation of this option, consider payment of DSH payments by other states to Washington hospitals.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – Psychiatric Services

Table A: Comparison of Washington Medicaid, Two Highest Scoring States and Medicare

Task	Questions	Washington	North Carolina	Indiana	Medicare
7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	• Washington State Medicaid uses a Ratio of Cost-to-Charges (RCC) methodology to pay for psychiatric services in psychiatric hospitals, distinct part pediatric psychiatric units and Medicare-certified distinct part psychiatric units in acute care hospitals. • Washington Medicaid pays for psychiatric services provided in acute care hospitals without distinct part units under the DRG methodology. • Psychiatric services are defined as those provided to patients with discharge diagnoses codes of 290 – 301 and 306 – 314. • Effective July 1, 2005, for free-standing psychiatric hospitals that are Involuntary Treatment Act (ITA)-certified by the Mental Health Division, Medicaid pays for patients with a diagnosis code of 290 – 301 and 306 – 314 by	• North Carolina Medicaid pays prospective per diem rates for psychiatric and substance abuse services provided in Medicare-certified distinct part units, other beds in acute care hospitals and in specialty psychiatric hospitals other than the state-owned psychiatric hospitals. • The per diem rates cover hospitals' operating and capital costs and apply to discharges from acute care hospitals classified in DRGs 424 – 437 and 521 – 523 and all services in specialty psychiatric hospitals. • A hospital's per diem rate is the lesser of its actual cost per day or the median cost per day as originally set in 1995, updated for inflation, with a per diem payment adjustment for reasonable graduate medical education costs for teaching hospitals. • In 2005 the State rebased its per	• Indiana Medicaid pays a prospective per diem rate for psychiatric services. The per diem rate applies to discharges classified in DRGs 424 – 432, except for certain principal diagnoses in DRG 429. • A hospital's per diem rate is comprised of two components: – A statewide operating cost per diem that is set at the average cost per day for the hospital that represents the median number of psychiatric cases. The per diem operating cost rate is rebased periodically by converting hospitals' charges from claims to costs using hospital-specific ratio of cost-to- charges. In between rebasing periods, the operating cost per diem rate is updated for inflation. – A statewide capital costs per	• Medicare implemented a Psychiatric Facility Prospective Payment System on January 1, 2005. Prior to implementing this system, psychiatric services provided in distinct part units and psychiatric hospitals were exempt from the Medicare DRG Prospective Payment System for acute care services because Medicare acknowledged that the DRG classification system, which is based ICD-9-CM diagnoses, does not adequately differentiate psychiatric diseases and disorders in terms of the resource needed to treat them on a per case basis. • The Medicare Psychiatric Facility Prospective Payment System was developed using 2002 cost report and claims data for psychiatric facilities. The system is based on a federal per diem base rate comprised of labor and non-labor shares that is subject to five different patient characteristic adjustments:

Task	Questions	Washington	North Carolina	Indiana	Medicare
		comparing the amount they would be paid under the RCC methodology divided by the patient's approved length of stay with a base psychiatric rate per day of $550. Medicaid pays the higher of the two amounts times the patient's approved number of days. – This change was a result of a legislative proviso to address a perceived shortage of hospital beds ITA patients. – There are currently only four freestanding psychiatric hospitals that have ITA certified. • Under Washington's waiver for mental health services, Regional Support Networks (RSNs) are county-or groups of county-based organizations that act as managed care entities to coordinate mental health services for Medicaid eligible and non-Medicaid clients.	diem rate using 2003 or the most recent as-filed cost reports and CMS is reviewing a SPA that will make these rebased rates effective as of July 29, 2005. • Teaching hospitals also receive per diem rate adjustments for their hospital-specific graduate medical education costs. • Effective April 1, 2005, mental health services for Medicaid recipients in five counties are being provided under a waiver. The State makes a capitation payment to the single county-based managed care organization, and the capitation payment covers all mental health services, including inpatient and outpatient hospital care. The managed care organization negotiates its own fee-for-service rates with providers and adjudicates and pays all provider claims.	diem rate. • Teaching hospitals also receive per diem rate adjustments for their hospital-specific graduate medical education costs.	– Age – nine categories – DRG – 15 DRGs – Comorbidities – 17 possible groupings – Variable Per Diem Factors to recognize the higher costs incurred in the early days of a stay – Electroconvulsive Therapy – set dollar amount • There are also facility characteristic adjustments: – Rural location – Teaching status – Wage index for urban vs. rural location • The system includes a lump sum outlier payment for high cost outlier cases. • There is a four-year transition period during which hospitals' payments are based on a blend of the former cost-based payment and the Prospective

Task	Questions	Washington	North Carolina	Indiana	Medicare
		– Washington Medicaid pays the RSNs monthly capitation amounts. – For inpatient hospital services, the RSNs' role is limited to prior authorization of admissions; RSNs do not negotiate rates with hospitals and do not adjudicate their claims. Instead, Washington Medicaid processes hospitals' claims and pays the claims based on Medicaid's methodology. – Medicaid withholds from the RSNs' monthly capitation payments amounts for estimated inpatient hospital services and then settles with actual hospital paid claims. • Prior to the last legislative session, the State was required to contract with RSNs, but the Washington Legislature recently passed a law that requires the RSNs to demonstrate they can function as full-service managed			Payment. In addition, during the transition period hospitals are guaranteed an average payment per case no less than 70 percent of their payment under the former payment system.

Task	Questions	Washington	North Carolina	Indiana	Medicare
		care entities, including negotiating rates with hospitals and paying hospital claims. – The State has issued a Request for Qualifications whereby RSNs must demonstrate their capabilities to provide all managed care functions beginning September 2006. – In regions where the RSNs do not have such capabilities, the State can contract with other managed care entities, and if none is interested, mental health services for Medicaid clients in the region(s) will revert to the fee-for-service plan, and the State will maintain the responsibility for mental health services, similar to other fee-for-service clients.			

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	North Carolina	Indiana	Medicare
Strengths	• The RCC methodology, by reflecting individual hospitals' estimated cost experiences, accounts for patient acuity differences that affect resource utilization. • The RCC methodology, to some extent, reflects individual hospitals' cost experiences, thus hospitals do not have incentives to limit the psychiatric services they provide to those that are reasonable and necessary.	• Per diem payment accounts for patient acuity differences that affect length of stay. • By capping the per diem rate at the median cost per day, North Carolina provides an incentive for hospitals to control their costs, especially those whose costs are above the median. • Setting per diem rates on a base year and then applying inflation update factors that the State determines, offers North Carolina predictability of and control over its expenditures for psychiatric services. • Using the psychiatric DRGs to define which cases to pay on a per diem basis requires hospitals to follow the same billing and coding requirements as for patients paid for under the DRG methodology.	• Per diem payment somewhat accounts for patient acuity differences that affect length of stay. • Setting the operating per diem payment rate at the median of the average cost per day amounts provides an incentive for hospitals to control their costs, even for hospitals whose costs are below the median. • Setting the per diem rate on a base year and then applying inflation update factors that the State determines, offers Indiana more predictability of and control over its expenditures for psychiatric services. • Using the psychiatric DRGs to define which cases to pay on a per diem basis requires hospitals to follow the same billing and coding requirements they require for patients paid for under the DRG methodology.	• The system accounts for patient characteristics that can affect length of stay as well as cost per day. • The system is based on data that is currently available on claims, so there is no changes in claim submission requirements. • The system does not require changes in coding requirements. • Any hospital that provides services to Medicare patients has experience, albeit limited, with the system.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – Psychiatric Services

	Washington	North Carolina	Indiana	Medicare
Challenges	• Washington employs a different payment methodology for psychiatric services depending on where they are provided, i.e., DRG for acute care hospital without distinct part unit and RCC for distinct part units and specialty psychiatric hospitals, which may result in some inequities of payment. • The RCC methodology does not offer the State predictability of or control over its expenditures for psychiatric services. The greater the charges, the more the state pays. • If hospitals' charges increase at greater rates than their costs, applying past years' RCCs to current claims results in potential overpayment of hospitals costs. • The RCC methodology does not provide an incentive for hospitals to control their costs.	• A per diem payment rate for all psychiatric services provided by a hospital does not account for patient acuity differences that affect resource utilization per day. • Per diem payment does not provide hospitals with an incentive to control length of stay, so concurrent utilization review is necessary to assure that all inpatient days are medically necessary.	• A per diem payment rate for all psychiatric services provided by a hospital does not account for patient acuity differences that affect resource utilization per day. • Per diem payment does not provide hospitals with an incentive to control length of stay, so concurrent utilization review is necessary to assure that all inpatient days are medically necessary.	• The system is very new, so its impact is not yet known.

Table C: Psychiatric Services: Recommendations for Washington Medicaid

1. The State should evaluate the best way to pay for inpatient psychiatric services if they revert to FFS in any of the regions. To accomplish this, the State should analyze the costs of providing psychiatric services in specialty psychiatric hospitals, distinct part units and in acute care hospitals without distinct part units to identify variations in costs and to understand the reasons for such variations. This analysis will support a determination as to whether there should be different methodologies based on the provider type (i.e., acute care hospital, distinct part unit, free-standing psychiatric hospital).
2. The State should evaluate the feasibility of implementing a system based on Medicare's Inpatient Psychiatric Facility Prospective Payment System. Implementing a system based on Medicare's psychiatric and prospective payment systems would allow Washington Medicaid to pay for psychiatric services using a variable per diem approach that accounts for patient characteristics, such as age and comorbidities, that affect resource utilization. Concurrent utilization review would be necessary to assure that all days of a client's stay were medically necessary, but since per diem payment decreases as length-of-stay increases under the Medicare Inpatient Psychiatric Facility Prospective Payment System, the approach would create less incentive for longer lengths-of-stay.
3. If the State determines that the Medicare approach is not appropriate, it should consider evaluating the implementation of a fixed per diem payment system with concurrent utilization review. The design of a fixed per diem payment system will depend on the results of the analysis recommended above.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Selective Hospital Contracting Program

Table A: Comparison of Washington Medicaid and Two Other States

Task	Questions	Washington	California	Texas
8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	• Yes, the program known as Selective Contracting has been in place since 1988. Washington contracts with hospitals in certain urban areas of the State for inpatient services they provide to Medicaid fee-for-service clients. In areas of the State where selective contracting is in effect, Washington Medicaid does not pay for non-emergent services provided in non-contracted hospitals unless the hospital is exempt from the selective contracting program. • All services provided to Medicaid clients that are subject to the AP-DRG system in Selective Contracting Areas, except those services specifically excluded by the WAC, are subject to selective contracting.	• Yes; the program, known as Selective Provider Contracting Program (SPCP) has been in place since 1982. Under SPCP, the California Medical Assistance Commission (CMAC) contracts with hospitals for the services they provide to Medi-Cal fee-for-service patients in areas of the State, referred to as closed areas, where there are sufficient numbers of hospitals and Medi-Cal volume for competition among hospitals. The areas of the State where SPCP is not in effect, referred to as open areas, are rural areas, many of which have only one or a few small hospitals. • All inpatient services except psychiatric services are subject to the selective contracting program. • To be certain that Medi-Cal recipients have adequate access to inpatient hospital care under the SPCP, the CMAC annually compares the projected inpatient days needed to serve the Medi-Cal FFS population	• Texas' selective contracting program ended in 2004 when the State elected not to renew its waiver. Our preliminary investigations of the reasons for this decision suggest that the Texas Hospital Association opposed continuation of the program because it argued that the program required hospitals to provide discounts from rates that had budget reductions built into them and had been frozen since 2002. The State was also expanding its Medicaid managed care program, so over time, less volume was subject to the selective contracting program. • Based on a legislative mandate, the Texas Department of Health implemented its selective contracting program for acute care services in 1994 and for psychiatric services in 1995 and later combined the two programs into one. The program was in effect in metropolitan areas judged to have hospital competition and that did not have a Medicaid managed care pilot program underway. • The Department's intent was to be inclusive rather than exclusive in terms of the

Task	Questions	Washington	California	Texas
			with the number of vacant licensed beds in contracting hospitals by health planning area and by bed category, Med/Surg, OB, NICU, Ped, Rehab and Burn.	number of participating hospitals so as to lessen disruption to beneficiaries and hospitals. Therefore, the program did not include a volume management strategy to shift Medicaid inpatient hospital care from higher to lower cost hospitals. • Rather than negotiating contracts, the Department solicited bids from hospitals and accepted most of them without negotiating a lower than bid discount.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Selective Hospital Contracting Program

Task	Questions	Washington	California	Texas
8	What percentage of hospitals is included in the State's selective contracting program?	• All in-state hospitals that are eligible for selective contracting participate in the program and have since its inception. Until July 1, 2005, there were eight areas where selective contracting was in effect. In SFY 2004, selective contracting hospitals accounted for approximately 47 percent of total Medicaid FFS inpatient acute care cases. • On July 1, 2005, the State's program to earn federal Medicaid funds through the use of public hospitals' certified public expenditures (CPE) became effective, replacing the intergovernmental transfer program. Under the State's CPE program, public hospitals certify their qualifying expenditures that are used to draw federal Medicaid funds. Five public hospitals that had been paid under the selective contracting program are now participating in the CPE program. This has also reduced the number of contracting areas to six, because two areas were left with only one hospital each. (The third hospital in one of the areas converted to a critical access hospital and is thereby exempt from the selective contracting program). This reduced the number of selective contracting hospitals to 25.	• As of December 2004, there were 217 contracted hospitals out of nearly 500 hospitals in the State, but in areas where SPCP is in effect, 75 percent of all hospitals are contracted. SPCP-contracted hospitals accounted for 89.3 percent of total Medi-Cal FFS inpatient acute care days in SFY 2004.	• In the 24 areas of the State where the selective contracting program was implemented, all 202 acute care hospitals and most of the psychiatric hospitals that had been Medicaid providers before the program was implemented were initially awarded contracts.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Selective Hospital Contracting Program

Task	Questions	Washington	California	Texas
8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	• Negotiated conversion factors for the AP-DRG payment system. In areas of the state where selective contracting is in effect, the State negotiates a reduction from hospitals' adjusted cost-based conversion factors. Hospitals' negotiated conversion factors are publicly available. (For more detail related to the determination of cost-based conversion factors, see the Evaluation Matrix related to DRGs and Other Related Issues.)	• Negotiated per diem rates. All negotiated rates are confidential. Originally, some hospitals preferred per discharge payments, but as of the end of 2004, there were no contracting hospitals paid on an all inclusive per discharge basis, but six SPCP hospital contracts include per discharge rates for OB services.	• The most prevalent basis for payment was a percentage discount from the hospital-specific base DRG base rate for acute care services and a per diem amount for psychiatric services. The discount bids were not confidential.
	How often are contracts renegotiated?	• Terms vary from one to several years. When the State rebased the AP-DRG conversion factors effective January 1, 2001, the State encouraged contracting hospitals to consider renegotiating their conversion factors. The State recently increased rates for most hospitals, including those with hospital selective contracts, by 1.3 percent overall, with some hospitals receiving greater increases and some less depending on how their negotiated conversion rates compared with the caps for their peer groups.	• SPCP contracts are "evergreen" and are only renegotiated at the hospitals' or the Commission request.	• During the time the waivers were in effect, hospitals' initially-accepted discounted bid rates were updated for inflation periodically just as for hospitals in areas of the state where selective contracting was not in effect.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Selective Hospital Contracting Program

Task	Questions	Washington	California	Texas
8	Can non-contracting hospitals be paid for non-emergency inpatient services they provide to Medicaid patients?	• Yes, in areas of the State where selective contracting is in effect, non-contracting hospitals can be paid for services that are considered emergency, (e.g. labor and delivery). • The Washington Administrative Code also specifies that in areas of the state where the selective contracting program is in effect, Washington will pay for non-emergent inpatient medical services in a non-contracting hospital if the Medicaid client's travel distance to a contracting hospital exceeds travel distance standards for the client's county. • For Selective Contracting Areas, Washington Medicaid does not generally pay for non-emergency inpatient services at hospitals that choose not to participate in the Hospital Selective Contracting program. Washington State Medicaid does pay, if the hospitals and/or services are specifically exempted from the Hospital Selective Contracting program by the WAC.	• All elective admissions in contracting and non-contracting hospitals are subject to prior authorization review, and all cases are subject to concurrent review to assure that the length of stay is appropriate. If there is no available bed for the necessary medical service in a contracting hospital within a reasonable travel time, Medi-Cal will approve a stay in a non-contracting hospital and pay the non-contracting hospital based on a cost-based reimbursement system. All hospitals, both contracting and non-contracting, must submit cost reports annually and all are subject to audit.	• Information not available.

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	California	Texas
Strengths	• The selective contracting program enables the State to exercise its purchasing power to achieve lower payment rates through voluntary hospital participation.	• California has been aggressive in its negotiations and has been willing to exercise its market power. It initially rejected bids from several high Medi-Cal volume hospitals as a signal to all hospitals that it was more interested in achieving savings with a sufficient number of hospitals than including the maximum number of hospitals. This resulted in aggressive bidding by hospitals. • California's willingness to exclude hospitals makes the program more attractive to contracting hospitals because they have the potential to realize increased utilization as compensation for their rate concessions. • The confidentiality of the negotiated rates may result in more competitive negotiations than publicly available rates.	• The inclusive nature of the program enabled it to be implemented without disruption to beneficiaries and physicians. • In the early years of the program, the State was able to achieve some savings beyond those it could have in absence of selective contracting.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Selective Hospital Contracting Program

	Washington	California	Texas
Challenges	• Since all eligible hospitals in areas of the state where selective contracting is in effect participate and all are required to negotiate conversion factors that are below their calculated cost-based conversion factors, the program does not offer an advantage to low-cost hospitals. • Publicly available negotiated conversion factors may result in higher rates than a confidential process.	• Per diem payment requires strong concurrent utilization review to assure that all days of patients' stay are medically necessary	• The program did not include features that encouraged competitiveness among hospitals. • The inclusiveness of the program precluded any hospital from benefiting by offering a volume discount. • The discount from the hospital-specific base DRG rate did not offer any advantage to lower cost hospitals.

Table C: Selective Hospital Contracting Program: Recommendations for Washington Medicaid

1. The State should evaluate the need for selective contracting in the current environment and whether there are less administratively burdensome ways to achieve the State's health care access and cost containment goals. Consider discontinuing the Selective Hospital Contracting program.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Centers of Excellence

Table A: Comparison of Washington Medicaid and Two Other States

Task	Questions	Washington	Other Core Survey States
8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	• Yes. Washington State Medicaid pays for transplant and bariatric surgery services for Medicaid clients only when the procedures are performed in hospitals that are designated as Centers of Excellence. To attain and maintain the Center of Excellence designation, hospitals are evaluated on several criteria, including the following: – Annual volume requirements – Patient survival rates – Relative cost per case • Under the Centers of Excellence program, Washington State Medicaid pays for transplants and bariatric surgery using the RCC-based payment methodology.	• None of the core survey states had Centers of Excellence programs in place. NCI is not aware of any other states with significant Centers of Excellence programs.
8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	• No relevant comparative information.	• Information not available.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Centers of Excellence

Task	Questions	Washington	Other Core Survey States
8	Describe IP Centers of Excellence programs.	• No relevant comparative information.	• Information not available.
8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc? Describe.	• No relevant comparative information.	• Information not available.
8	Does the state require that hospitals designated as Centers of Excellence routinely report performance statistics?	• No relevant comparative information.	• Information not available.
8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	• No relevant comparative information.	• Information not available.

Task	Questions	Washington	Other Core Survey States
8	Does the global package rate for transplants include professional services and any pre- or post-transplant services.	• No relevant comparative information.	• Information not available.

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	Other Core Survey States
Strengths	• The Centers of Excellence program allows Washington Medicaid to direct specific services to the most qualified hospitals.	• Information not available.
Challenges	• The Centers of Excellence program may preclude some qualified hospitals from providing certain services.	• Information not available.

Washington State Medicaid
Inpatient Reimbursement System Study
Evaluation Matrix – Centers of Excellence

Table C: Centers of Excellence: Recommendations for Washington Medicaid

1. The State should evaluate the need for Centers of Excellence in the current environment and whether there are less administratively burdensome ways to achieve the State's health care access and cost containment goals. The State should consider this issue in conjunction with the evaluation of the Selective Contracting program. If Selective Contracting is maintained, the Centers of Excellence program may be a way to better define those facilities that can participate in Selective Contracting.
2. Consider adopting an alternative payment methodology for services currently covered under the Centers of Excellence program. For example, consider establishing fixed price payments for transplant services based on the payment levels currently in place for the Medicare program. Amounts could be adjusted to take into consideration the differences in resources between the Medicare and Medicaid population, and to meet the State's objectives for expenditures.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – Trauma Care Program

Table A: Comparison of Washington Medicaid and Two Highest Scoring States

Note: Washington and Illinois' programs include both Medicaid and non-Medicaid payments; we have provided a description of both to fully portray these states' trauma funding strategies.

Task	Questions	Washington	Texas	Pennsylvania	Illinois
9	What is the methodology of funding for the separate trauma payments?	• Washington makes payments for trauma care through the Trauma Care Reimbursement Fund (TCF), which pays for both Medicaid and non-Medicaid services (approximately $20.5 million annually). Medicaid and non-Medicaid are described separately, below: <u>Medicaid</u> • The State makes supplemental quarterly payments to Level I-III trauma hospitals ($11 million annually in State and federal funds) and physicians ($3.5 million annually in State and federal funds). Washington Medicaid bases each hospital's payments on: – The hospital's Medicaid reimbursement for inpatient and outpatient trauma care patients (only for patients with Injury Severity Scores of 13 or greater for adults, and nine or greater for	• Trauma payments in Texas are not funded through the Texas Medicaid program. However, hospitals must have a trauma facility designation to participate in the Medicaid DSH program (although a trauma care facility designation is not mandatory to otherwise participate in the Medicaid program). • Certain hospital types, such as psychiatric hospitals licensed by the State, rehabilitation hospitals and burn institutes are exempt from the trauma care DSH requirement,. • Texas uses add-on traffic fines to fund trauma facilities and emergency medical services (approximately $46 million in 2005). Eligible hospitals are those that have Level I, II, III or IV trauma facility designation. Four percent of allocated funding is retained to cover Texas Department of Health and Regional Advisory Council administrative expenses. Eligible hospitals may choose	• Pennsylvania Medicaid funds some trauma care with DSH payments (approximately $25 million annually), as follows: • Level I and II trauma hospitals receive 90 percent of the funds: – 50 percent of these funds are distributed equally among Level I and II trauma hospitals – 50 percent of these funds are distributed on the basis of each trauma hospital's percentage of Medicaid and uninsured trauma cases and patient days for Level I and Level II trauma hospitals (based on information gathered by the Pennsylvania Trauma System Foundation). • Pennsylvania pays the Level III trauma hospitals the remaining 10 percent of the funds, distributed as follows:	• Illinois' Trauma Center Fund supports both Medicaid and non-Medicaid services (approximately $9.1 million in 2005) and is generated from add-on traffic fines. Medicaid and non-Medicaid are described separately, below: <u>Medicaid</u> • Illinois distributes half of the trauma care fund quarterly to Level I and II trauma hospitals based on the number of trauma patients cared for by the hospital who are covered by Medicaid. – Illinois divides the quarterly trauma funds by each eligible hospital's Medicaid trauma admissions (based on diagnosis code). The result of the calculation is the trauma care adjustment

Task	Questions	Washington	Texas	Pennsylvania	Illinois
		children) – The hospital's Medicaid reimbursement for transferred trauma cases, regardless of the patient Injury Severity Score. <u>Non-Medicaid</u> • Non-Medicaid trauma funds are provided through various grant programs, as follows: – Uncompensated trauma care grants – Provided to Level I-III trauma hospitals based on a hospital's proportionate share of the cost of uncompensated trauma care for a certain period ($2.5 million annually). – Level IV and V and CAH trauma care grants – Annual fixed grants to support the costs of trauma care, including stabilizing patients for transfer to other designated facilities ($1.2 million annually). – Participation grants for prehospital agencies and Level I-V hospitals – To offset the costs of participating	to receive their portion of the remaining 96 percent using one of two options: – *Option 1* – 15 percent of the funding is divided equally among all eligible hospitals – funding for hospitals that choose Option 2 instead of this option is put into the Option 2 funding pool. – *Option 2* – 85 percent of the funding is distributed to eligible hospitals based on the percentage of uncompensated trauma care a hospital provides (charity and care bed debt) in relation to the total uncompensated care provided by all of the eligible hospitals that apply. • Texas also distributes 27 percent of a special emergency medical services fund (approximately $2.4 million annually) to fund uncompensated care for hospitals designated as state trauma facilities.	– 50 percent of the funds are allocated equally among Level III trauma hospitals – 50 percent of the funds are allocated on the basis of each trauma hospital's percentage of medical assistance and uninsured trauma cases and patient days compared to the statewide total number of medical assistance and uninsured trauma cases and patient days for all Level III trauma centers. • Payment to each qualifying Level III trauma hospital may not be greater than 50 percent of the average statewide annual payment to Level II trauma hospitals. • Pennsylvania's trauma care DSH payments are part of a larger DSH program (approximately $779 million in State and Federal funds per the 2002 CMS-64) that includes over 10 types of DSH payments targeting hospitals that provide	(TCA). – Illinois pays the TCA per Medicaid trauma admission for the applicable quarter. <u>Non-Medicaid</u> • The Illinois Department of Public Health awards the remaining half of the trauma care fund to hospital trauma centers in the geographic region where the traffic violations that funded the Trauma Care Fund occurred. Illinois bases the payment amount from the regional share on the number of trauma patient for whom the hospital receives care.

Task	Questions	Washington	Texas	Pennsylvania	Illinois
		in the State's trauma system (e.g., training, equipment, supplies and staffing), totally approximately $2.15 million annually) – Needs grants – For any prehospital agency that demonstrates a need for purposes of becoming or remaining verified to provide trauma care, meeting their obligations as defined in law, or meeting their responsibilities within their respective regional plans ($150,000 annually). • Washington Medicaid is in the process of adjusting its distribution of non-Medicaid funding to provide a greater proportion of funding to Level III facilities. Level IV facilities are currently receiving more funding (Medicaid and non-Medicaid) than Level III facilities.		high volumes of care to Medicaid and the uninsured.	
9	How does the State define trauma care for payment	• Injury Severity Scores of 13 or greater for adults, and nine or greater for children	• Care provided to patients who meet the following requirements: – Have at least one of the following ICD-9 codes: between 800.00 and	• Pennsylvania uses ICD-9 codes in conjunction with selected other criteria; NCI is awaiting a list of exact criteria from the Pennsylvania Trauma Systems	• Illinois defines trauma care using the following ICD-9-CM principal diagnosis codes: – 800.0 through 809.1

Task	Questions	Washington	Texas	Pennsylvania	Illinois
	purposes?		959.9, including 940.0-949.0 (burns), excluding 905.0-909.0 (late effects of injuries), 910.0-924.0 (blisters, contusions, abrasions, and insect bites) and 930.0-939.0 (foreign bodies), and – Underwent an operative intervention (any surgical procedure resulting from a patient being taken directly from the emergency department to an operating suite regardless of whether the patient was admitted to the hospital), or – Was admitted as an inpatient for greater than 23 hours, or – Died after receiving any emergency department evaluation or treatment, or – Was dead on arrival to the facility, or – Transferred into or out of the hospital.	Foundation.	– 828.0 through 828.1 – 839.0 through 839.3 – 839.7 through 839.9 – 850.0 through 854.19 – 860.0 through 861.32 – 862.8 and 863.0 through 869.1 – 887.0 through 887.7 – 896.0 through 897.7 – 900.0 through 900.9 – 902.0 through 904.9 – 925 and 926.8 – 929.0 through 929.99 – 958.4 and 958.5 – 990 through 994.99

Table B: Strengths and Challenges of Selected States' Methodologies

	Washington	Texas	Pennsylvania	Illinois
Strengths	• Provides funding for patient trauma care and for maintaining trauma care capabilities. This dual funding approach assists hospitals in covering costs associated with patient care and the fixed cost of maintaining a certain level of trauma care services. • Provides funding to the wide variety of providers involved in the trauma care system. • Distributes the majority of the funding to hospitals with the highest trauma designation; these hospitals likely incur the highest unreimbursed trauma care costs. • Targets Medicaid supplemental trauma payments to both hospitals and physicians, both of which incur additional costs for providing trauma care. • Payments reflect hospital resource use as Medicaid payments are distributed based on the relative volume of trauma care provided.	• Provides funding to the wide variety of providers involved in the trauma care system. • Payments reflect hospital resource use as payments are distributed based on the relative volume of trauma care provided. • Hospitals have strong incentives to obtain trauma care designation as Medicaid DSH funding and non-Medicaid trauma care payments require this designation.	• Distributes the majority of the funding to hospitals with the highest trauma designation; these hospitals likely incur the highest unreimbursed trauma care costs. • Payment distribution formula considers the unreimbursed costs of both Medicaid and uninsured trauma care patients, so payments will vary by hospital resource use.	• Distributes the majority of the funding to hospitals with the highest trauma designation; these hospitals likely incur the highest unreimbursed trauma care costs. • Distributes a portion of the Medicaid payments based on the relative volume of Medicaid trauma care provided, so payments will vary by hospital resource use.

Washington State Medicaid
Inpatient Hospital Rebasing Project
Evaluation Matrix – Trauma Care Program

	Washington	Texas	Pennsylvania	Illinois
Challenges	• Payments are not tied to Medicaid trauma care shortfalls, so hospitals may potentially receive payments in excess of Medicaid trauma care costs • It is not clear if Level III hospitals are fully reporting trauma care cases as their Medicaid trauma care payments are lower than Level IV hospital trauma care payments.	• Funding is not targeted to all trauma care as only hospitals with an official trauma care designation may receive payments • Funding is not targeted to facilities providing the highest level of trauma care (e.g., Level I and II facilities)	• A portion of Pennsylvania's trauma care funding is distributed equally among Level I and II trauma hospitals. While this distribution approach may help all of these hospitals maintain trauma care capabilities, it may not target those hospitals with the highest unreimbursed costs. • Pennsylvania's trauma care strategy does not target a wide range of providers (e.g., physicians or Level IV-V trauma care providers). • Payments are not tied to trauma care Medicaid shortfalls, so hospitals may receive more payments than their Medicaid costs.	• Payment amounts are not linked to trauma care services for the uninsured, which typically represent a large proportion of uncompensated trauma care. The disconnect between trauma care payment distribution and unreimbursed uninsured trauma care may mean that payments are not targeted to hospitals with the highest combined Medicaid and uninsured uncompensated trauma care costs. • Non-Medicaid payments are linked to the amount of traffic fines levied in a hospital's geographic region; it is not clear that these fines are associated with increased trauma care cases.

Table C: Trauma Care Program: Recommendations for Washington Medicaid

1. The State should assess the extent to which total Medicaid payments for trauma services (DRG- or RCC-based payments and supplemental trauma care payments) cover estimated hospital costs over time.
2. Washington Medicaid should collaborate with the Department of Health to conduct a study of uncompensated trauma care (Medicaid and other payers) to determine which trauma care providers (e.g., hospitals, physicians, ambulance providers and others) incur the greatest unreimbursed trauma care costs and use the results of this study to asses the current trauma care payment distribution (Medicaid and non-Medicaid) methodology.